Introduction

The 1998 National Drug Control Strategy is a ten-year plan to reduce drug abuse and its consequences in the United States. The annual strategy is developed under the leadership of General Barry R. McCaffrey, Director of the Office of National Drug Control Policy (ONDCP), in close consultation with the more than 50 Federal agencies and departments involved in drug control efforts as well as State- and local-level law enforcement personnel, treatment/prevention professionals, and stakeholders drawn from every segment of our society. The 1998 Strategy's five goals and 32 objectives comprise a comprehensive, balanced effort that encompasses drug prevention, treatment, domestic law enforcement, protection of our borders, and international cooperation.

The primary goal of the Strategy "is to educate and enable America's youth to reject illegal drugs as well as alcohol and tobacco."[1] This priority was reinforced in testimony before Congress by the Director of ONDCP, who said:

> "The centerpiece of our national anti-drug effort must be to prevent the use of illegal drugs, alcohol, and tobacco by our children. . . . [The 1998 Strategy's] number one priority is to reinvigorate what must be a national anti-drug effort on behalf of our children."[2]

The Substance Abuse Prevention and Treatment (SAPT) Block Grant is a Federal program designed to allocate funds for prevention and treatment activities for alcohol, tobacco, and other drug (ATOD) abuse. Federal Block Grant funding for prevention programs for ATOD abuse was mandated through a revision of Federal law in 1989 and once again in 1993. One of the objectives of this program is to reduce substance abuse in a given State or Territory through an earmarked 20 percent of SAPT Block Grant funds that are to be used exclusively for prevention activities. Federal regulations state that the 20 percent set-aside must be spent on programs for individuals who do not require treatment for substance abuse, as well as on programs designed to educate, counsel, and provide activities to reduce the risk of abuse in a given community.

While there are substantial amounts of data available on drug treatment efforts, relatively little data on drug abuse <u>prevention</u> efforts exist to date.

According to the Federal Register (volume 58, number 60, March 31, 1993) Rules and Regulations:

> "Sections 1921 to 1954 of the Public Health Service (PHS) Act authorize the Secretary to provide Block Grants to States for the purposes of prevention and treatment of substance abuse which includes alcohol and other drugs. . . . The Block Grant funds may be expended to provide for a wide range of activities to prevent and treat substance abuse and may be expended to deal with the abuse of alcohol, the use or abuse of illicit drugs, the abuse of licit drugs and the use or abuse of tobacco products."

The Public Health Act goes on to specify that not less than 20 percent of a Block Grant to a State is to be expended for primary prevention activities:

> "Section 96.125 . . . requires States to develop a comprehensive prevention program which provides a broad array of prevention activities and services including such activities and services to discourage the use of alcoholic beverages and tobacco products by minors. These activities and services must be provided in a variety of settings for both the general population, as well as targeted subgroups who are at high risk for substance abuse."

Section 96.121 of the Public Health Act defines primary prevention programs as follows:

> "Primary prevention programs are those directed at individuals who have not been determined to require treatment for substance abuse. Such programs are aimed at educating and counseling individuals on such abuse and providing for activities to reduce the risk of such abuse."

One of ONDCP's responsibilities is to document how available Federal resources are used to prevent and treat drug abuse within the context of the National Drug Control Strategy. Towards that end, ONDCP gathers data on program initiatives for dissemination to Congress, Federal agencies, and the American public. While there are substantial amounts of data available on drug treatment efforts (e.g., characteristics of those served in treatment programs, indicators of treatment effectiveness), relatively little data on drug abuse *prevention* efforts exist to date. State ATOD agencies are responsible for a large portion of this country's drug prevention efforts in collaboration with communities, other State agencies, and Federal officials. This report was prepared by the National Association of State Alcohol and Drug Abuse Directors (NASADAD) in order to detail how State ATOD agencies utilize funds from the SAPT Block Grant in meeting the Federal legislative mandate that not less than 20% of those monies be expended for primary prevention programs.

[The Prevention Inventory] is the first of its kind to document the activities of all 50 States and the District of Columbia funded by the 20% prevention "set-aside" formula.

Although State ATOD agencies currently produce a number of reports and documents that describe their activities, this Inventory is the first of its kind to document the activities of all 50 States and the District of Columbia funded by the 20% prevention "set-aside" formula. Inventory data were compiled through a thorough review of SAPT Block Grant applications, Center for Substance Abuse Prevention (CSAP) Prevention Technical Assistance to States Project site visit reports, U.S. Census data, and other documents provided by the State ATOD agencies. As stated in the 1998 National Drug Control Strategy:

> "The key to a successful long-term strategy is mobilizing resources toward the achievement of measurable goals."

Thus, the overall goal of *this* undertaking is to provide a document that outlines the *systems* and *resources* currently in place at the State level for substance abuse (i.e., abuse of alcohol, tobacco, and illicit drugs) prevention. The specific objectives of this report are to:

- Identify and describe the scope and nature of State ATOD agency prevention systems, as funded by the 20% set-aside.

- Analyze and describe how prevention expenditures are channeled and distributed at the State and substate levels.

The Inventory has been organized in the following manner. The methodology section describes how the data and information were gathered and which Federal- and State-level documents were examined. An explanation of the format and type of information presented in each individual State profile is also provided. This is followed by an aggregate profile which discusses major themes and trends of Block Grant-funded substance abuse prevention activity from a national perspective. A section that presents case studies of representative prevention programs in four States follows, which is subsequently followed by individual profiles of the 50 States and the District of Columbia.

This Inventory can become part of a "blueprint" used by States to guide and advise them as they develop prevention programming. This examination and review of State prevention systems is intended to serve as a key reference for Federal and State government officials, the service provider community, and other members of the public that work with – and have an interest in – State ATOD prevention efforts. By highlighting the programs and accomplishments of States, ONDCP is fostering the vital State-to-State "mentoring" that many officials report is most valuable as a means of becoming educated and enlightened. This Inventory will enable State Directors and policymakers to learn about prevention efforts in other States, and to replicate programs and methodologies that have been successful for specific target groups. Additionally, community-based organizations working on alcohol and drug abuse prevention can use these data to identify the best methods of complementing, supplementing, or enhancing State-funded activities in prevention. Ultimately, this Inventory should help to broaden the dialogue on substance abuse prevention efforts within the States.

Endnotes:

1 Office of National Drug Control Policy, The White House, 1997, *The National Drug Control Strategy, 1998: A Ten Year Plan*, page 3.

2 Statement by General Barry R. McCaffrey, Director, Office of National Drug Control Policy, before the Senate Appropriations Committee, Subcommittee on Treasury, General Government, and Civil Service, May 14, 1997.

Methodology

Introduction

This document was prepared in order to detail how State ATOD agencies utilize funds from the SAPT Block Grant in meeting the legislative mandate that at least 20 percent of the Block Grant be allocated for primary alcohol and illicit drug (and, in some instances, tobacco) prevention programs. The Inventory captures prevention activities that are funded wholly or partially by the 20% set-aside. NASADAD staff conducted a number of activities to gather the documentation needed to complete the Inventory. A detailed Request for Information (RFI) was sent to State ATOD agency directors in the 50 States and the District of Columbia (the offshore Territories were excluded from this study) requesting relevant materials for this study (the RFI is contained in Appendix C). Critical review of available documents and telephone interviews with key State ATOD agency staff were among the methods used to gather data. The overall approach was grounded in the belief that most of the documentation needed to complete the Inventory currently exists and that any additional data could be provided by the States themselves.

At the outset of this project, the National Association of State Alcohol and Drug Abuse Directors (NASADAD) conducted an "environmental scan" in order to assess the types of information sources that are currently available and to determine how they can best be used in the compilation of this inventory. The sources utilized in preparing the data and information contained within this document included:

- U.S. Census figures
- Substance Abuse Prevention and Treatment Block Grant applications
- Materials sent by the States
- Direct input/feedback from States
- Previous NASADAD materials and documents

The environmental scan also included informant discussions with the NASADAD Prevention Committee and the National Prevention Network (NPN) Executive Committee. The NPN is a subsidiary of NASADAD and is comprised of all the State and Territorial prevention coordinators. These contacts took place during the 1997 NASADAD/NPN Annual Meeting in Portland, Maine. The NASADAD Prevention Committee and NPN Executive Committee were also given the opportunity to review and comment on the draft Inventory workplan and provide substantive feedback on how to improve the list of sources and the draft document. ONDCP and NASADAD realize that this type of report contains information that changes rapidly. Therefore, every attempt was made to gather and present the information in a format that is simple to update and provides

State agencies . . . working in prevention should examine this report and seek ways to improve substance abuse prevention and move beyond the current levels of knowledge and expertise.

succinct summaries of State prevention activities. This type of report is also very valuable not only as a tool to document the current work in the field, but also as a "roadmap" to the future. State agencies and others working in prevention should examine this report and seek ways to improve substance abuse prevention and move beyond the current levels of knowledge and expertise.

Sources of information

A description of the sources utilized in preparing the data and information contained within this inventory is presented below:

U.S. Census figures. U.S. Census figures have been utilized in the "Funding and Resources" section of each State profile. Specifically, Census figures have been used to calculate each State's per capita spending of the SAPT 20% set-aside amounts over the course of the three Federal Fiscal Years (FFY 1993-1995). Since the most recent census count – which took place April 1, 1990 – the Bureau of the Census has produced estimates of State populations for each successive year, up to and including 1994. It is these Census Bureau estimates that we have used in calculating the per capita spending in FFY 1993 and FFY 1994. For 1995, and for every fifth year thereafter (i.e., 2000, 2005, 2010, etc.), the Census Bureau has produced population projections based on the "cohort-component" model, which utilizes various assumptions on State-to-State migration patterns.[1] We have used this projection in our reporting of FFY 1995 per capita data.

Substance Abuse Prevention and Treatment Block Grant applications. One of the richest sources of data and information has been the Substance Abuse Prevention and Treatment (SAPT) Block Grant application. Each State, Territory, and the District of Columbia submits a Block Grant application to the Substance Abuse and Mental Health Services Administration (SAMHSA) detailing its proposed activities and expenditure of resources as well as a report of prior year activity. The Federal Government has stipulated that 20% of this funding is "set aside" for the exclusive purpose of financing substance abuse prevention activities. In addition to the prevention set-aside, other set-asides mandated in the Block Grant include:

- Alcohol-related activities (35%)
- Other drug activities (35%)
- Alcohol/drug treatment services for pregnant women and women with dependent children (10%)
- Early intervention services for HIV-positive clients (2-5%)[2]

NASADAD obtained copies of each State's (and the District of Columbia's) Block Grant applications for FFY 1996-1998. These fiscal years were chosen because the applications have been completely processed, and were archived at the SAMHSA Office of Grants

Management.[3] Taken together, the Block Grant applications from the three fiscal years have provided the following information:

- Dollars expended in FFY 1993-1995.
- Total grant amount, 20% set-aside, State expenditure for prevention (if any), expenditure by CSAP strategy, resource development expenditure.
- Average amount of grants or contracts to substate entities.
- Additional information on prevention programs at the state, substate, and local levels, including strategies, numbers of programs, and number of individuals served.
- Needs assessments, data collection activities, and program evaluations.
- Training and technical assistance.
- Certification of prevention professionals, if applicable.

Materials sent by States. At the outset of this project, NASADAD requested relevant agency reports, documents, brochures, and other materials from each State Director and NPN Representative. The materials submitted by the States included financial data, descriptions of funding streams or mechanisms, evaluation findings, and dollar amounts allocated to local programs. Additional materials received by NASADAD included various State Prevention Plans, the most recent prevention site visit reports from the Center for Substance Abuse Prevention (CSAP) contractor,[4] and *Healthy People 2000* interim reports, which highlight accomplishments in health, substance abuse, and/or mental health services.

A complete listing of materials sent by the States is listed in Appendix B of this Inventory.

Direct input/feedback from the States. Each draft State profile was forwarded to the State ATOD agency for review and comment. In addition, NASADAD staff contacted key prevention staff, and solicited feedback via electronic mail as appropriate. Their amendments or corrections were incorporated into the final profiles that appear in this inventory.

Previous NASADAD survey instruments and reports. As part of its ongoing role to gather, synthesize, and disseminate information on State agencies, NASADAD periodically conducts surveys of its members. These findings, often the most current information available on State ATOD agencies, were also used as an information source for the State profiles in such subject areas as the status of prevention certification efforts, the structure of State prevention systems, and the States' prevention expenditures.

Potential Limitations of this Document

Although this Document provides considerable information on state prevention activity funded by the 20% set-aside, potential limitations exist. Some limitations include:

Some of the challenges of preparing a report documenting prevention lie in the lack of a uniform nomenclature to describe prevention activity and a concomitant data set.

Multiple funding streams for prevention. Great care has been exercised in reporting those activities (e.g., prevention programs, training and technical assistance, needs assessments) that receive at least *a portion* of their funds from the 20% set-aside. Some States traditionally blend multiple funding streams to finance their prevention-based activities. Sources of alternative funding streams include other contracts from the Center for Substance Abuse Treatment (CSAT) and from CSAP, Governors' Portions of the Safe and Drug-Free Schools and Communities Act, State General funds, and liquor sale license fees, among others. To reflect this reality, we have carefully annotated the information within each State profile accordingly to identify multiple funding streams. We have also included State expenditure levels for prevention for FFY 1993-1995.

States differ in their data collection and reporting capabilities. Essentially three reasons exist for this State-by-State variability:

- Some States' management information systems (MIS) were unable to capture categorical data in the timeframe reported in this Document. For example, California, which implemented a statewide data collection system in early 1998, did not have a fiscal reporting system in place during FFY 1993-1995 that collected information in a format that allowed responses to some of the specific questions asked. Furthermore, for those financial data that were tracked during this time period, California's allocation methodology differed from the framework of the NASADAD State prevention profile.[5] In Michigan, which may be considered typical of several States, the State tracked the number of contracted prevention providers that received Federal Block Grant monies. However, the State did not tabulate the actual number of persons reached or served in each of the categorical prevention strategy areas.

- Some States found themselves in an organizational state of flux. For example, in Minnesota and Florida, significant changes have occurred to either the organizational structure or the staffing of the States' alcohol and other drug (AOD) abuse agencies, including their Prevention Offices. Since these changes took place during the compilation of this report, the data reported herein reflect the prevention staffs' best estimates (these estimates have been annotated accordingly).

- Inherent challenges were faced by the frontier States. By definition, a "frontier" State is any State in which fewer than six residents per square mile reside in at least 50% of the State's counties. Such States (e.g., Alaska, Montana, North and South Dakota) encompass vast, sparsely-settled territories, and often have State Prevention Offices that are staffed by only one full-time equivalent (FTE). Challenges exist in providing

accurate assessments of the number of individuals served by various prevention programs in these States. Again, estimates (when used) have been annotated accordingly in this report.

There is no widely accepted standard prevention nomenclature. Some of the challenges of preparing a report documenting prevention lie in the lack of a uniform nomenclature to describe prevention activity and a concomitant data set. As a result, some prevention activities that do not "fit" into one of the definitions presented in the inventory may not be adequately captured.

Conflicting time periods under consideration. In some cases the States struggled with reporting activities for the fiscal years selected for the report. In some States, there are differences between State and Federal fiscal years. By using several consecutive years this issue was partially addressed; however, the issue of multi-year programming – often funded from multiple sources – made it difficult for States to differentiate program years.

Endnotes:

1 U.S. Department of Commerce, Economics and Statistics Administration, Bureau of the Census. "Current Population Reports. Population Projections: States, 1995-2025," May 1997. For further information, one can access the Census Bureau's website at http://www.census.gov/population/www/projections/stproj.html.

2 The SAPT Block Grant requires designated States to use between 2-5% of their allotments on early intervention services for HIV-positive clients. "Designated" States are defined as those with an incidence of acquired immune deficiency syndrome (AIDS) of 10 or more per 100,000 residents.

3 The reality of time lags in the reporting of data and information was a factor in choosing to analyze Block Grant applications from FFY 1996-1998. Most data systems have a lag of at least one year between the time when information is collected and when it is subsequently reported. In the specific case of Block Grant applications, States have two years to spend their allocations, with expenditure reporting occurring in the third year. For example, the FFY 1996 Block Grant application reports financial resources that were expended in FFY 1993.

4 In October 1992, the Center for Substance Abuse Prevention (CSAP) launched "Prevention Technical Assistance to the States," a significant project for strengthening State and Territorial prevention systems. Through this project, CSAP has worked closely with State ATOD agencies to identify opportunities for improving their prevention systems. Technical assistance (TA) needs have been identified primarily through special CSAP Prevention Technical Assistance Site Visits, that have been conducted by Birch & Davis Associates, Inc., a health and social sciences consulting firm located in Silver Spring, Maryland. Funding for this project is separate from the SAPT Block Grant.

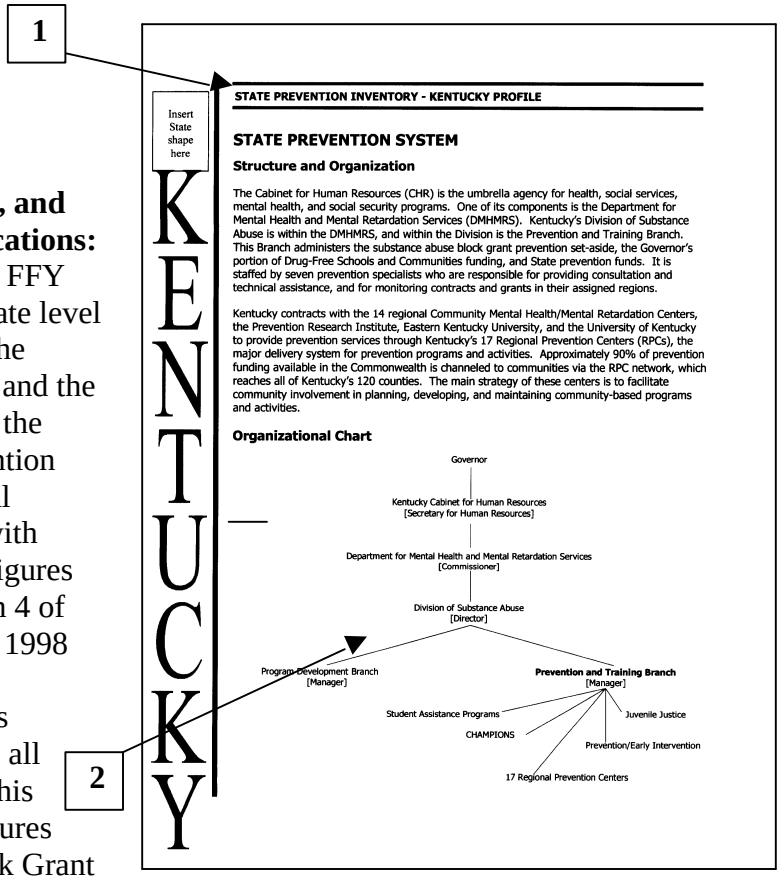
5 To illustrate this point further, one portion of the Funding and Resources section of each profile reports on the "average amount of the grant/contract" for each Federal Fiscal Year. The underlying assumption is that such grants or contracts are awarded to individual provider agencies on a competitive basis. It is not consistent with California's methodology to determine the average amount of the grant or contract. Instead, California utilizes an allocation methodology that is based upon each county's population; those counties with fewer than 100,000 residents are guaranteed a minimum level of Federal funds.

Explanation of State Profile Components

Section I – State Prevention System

1. **Structure and Organization:** This narrative portion describes the overall structure and role of the State agencies that are charged with receiving and administering the SAPT Block Grant from SAMHSA. Information is provided on the State hierarchical structure, the substate entities (e.g., regions, counties, individual agencies) with whom the State agency works, and the flow of funds from SAMHSA to the State agency and onwards to the regional and local level.

2. **Organizational Chart:** A graphical depiction of the State hierarchical structure is presented.



Section II – Funding and Resources

3. **State, Block Grant, and 20% set-aside allocations:** Funding received in FFY 1993-1995 at the State level for prevention, for the SAPT Block Grant, and the amount allocated to the 20% primary prevention set-aside, as the final figures negotiated with SAMHSA. These figures are taken from Form 4 of the 1996, 1997, and 1998 SAPT Block Grant applications. Unless otherwise indicated, all figures reported in this section are expenditures reported in the Block Grant application. It should be noted that States are not permitted to spend less than 20% of their SAPT allocations on prevention-related activities.

4. **CSAP Strategy:** Details the spending on programs and services by the Center for Substance Abuse Prevention's (CSAP) six strategies as presented in the Block Grant application chart, *Expenditures on Primary Prevention and Intervention.* Strategy areas are defined as follows:

Information Dissemination: Provides awareness and knowledge of the nature and extent of alcohol, tobacco and other drug (ATOD) use, abuse, and addiction as well as their effects on individuals, families, and communities. It also provides knowledge and awareness of available prevention programs and services. It is characterized by one-way communication from the source to the audience, with limited contact between the two. Examples include (but are not limited to) clearinghouse/information resource center(s); resource directories; media campaigns; brochures; radio/TV public service announcements; speaking engagements; health fairs/health promotion; and information hot lines.

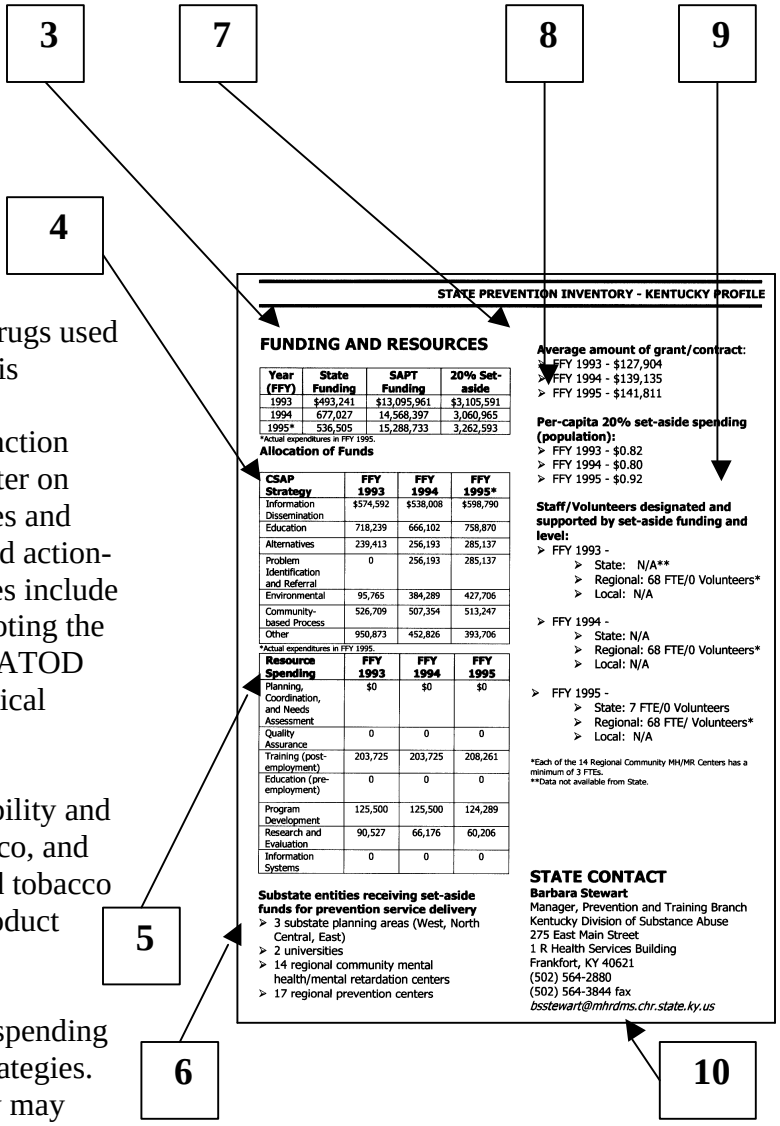
Education: Involves two-way communication and is distinguished from the Information Dissemination strategy by the fact that interaction between the educator/facilitator and the participants is the basis of this communication. Activities under this strategy aim to affect critical life and social skills, including decision-making, refusal skills, critical analysis (of media messages, for instance), and systematic judgement abilities. Examples include (but are not limited to) classroom and/or small group sessions (all ages); parenting and family management classes; peer leader/helper programs; education programs for youth groups; and children of substance-abusing parents.

Alternatives: Provides for the participation of target populations in activities that exclude ATOD use. The assumption is that constructive and healthy activities offset the attraction to, or otherwise meet the needs usually filled by alcohol/tobacco/drugs and would thereby minimize or obviate resort to the latter. Examples include (but are not limited to) drug-free dances and parties; youth/adult leadership activities; community drop-in centers; and community service activities.

Problem Identification and Referral: Aims to identify those who have indulged in illegal or age-inappropriate use of tobacco or alcohol and those individuals who have indulged in the first use of illicit drugs in order to assess if their behavior can be reversed through education. It should be noted, however, that this strategy does not include any activity designed to determine if a person is in need of treatment. Examples include (but are not limited to) employee assistance programs; student assistance programs; and DUI/DWI education programs.

Community-based Process: Aims to enhance the ability of the community to more effectively provide prevention and treatment services for ATOD abuse disorders. Activities include organizing, planning, enhancing efficiency and effectiveness of services implementation, inter-agency collaboration, coalition building, and networking. Examples include (but are not limited to) community and volunteer training (e.g., neighborhood action training); training of key people in the system; staff/officials training; systematic planning; multi-agency coordination and collaboration; accessing services and funding; and community team-building.

Environmental: Establishes or changes written and unwritten community standards, codes, and attitudes, thereby influencing the incidence and prevalence of the abuse of



alcohol, tobacco, and other drugs used in the general population. This strategy is divided into two subcategories to permit distinction between activities which center on legal and regulatory initiatives and those that relate to service and action-oriented initiatives. Examples include (but are not limited to) promoting the establishment and review of ATOD use policies in schools; technical assistance to communities to maximize local enforcement procedures governing availability and distribution of alcohol, tobacco, and drugs; modifying alcohol and tobacco advertising practices; and product pricing strategies.

Other: Designed to capture spending outside the six prevention strategies. Expenditures in this category may include Section 1926 (i.e., Synar Amendment) compliance; the hiring of contractors to provide specific technical assistance; resource development activities, such as quality assurance, research/evaluation, and information systems (this is described in greater detail below); and other primary prevention activities that can not be classified under the six prevention strategies.

5. **Resource spending:** Describes the amount expended from the SAPT Block Grant for prevention resource development activities such as planning, coordination, needs assessment, quality assurance, training of counselors, program development, research and development, and the development of information systems. Figures used are reported in the SAPT Block Grant application. Expenditures on resource development activities may involve the time of State or substate personnel, or other State or substate resources. These activities may also be funded through contracts, grants, or agreements with other entities. It should be noted that data presented in this table was voluntarily reported by the States.

Planning, coordination, and needs assessment: This includes State, regional, and local personnel salaries pro-rated for time spent in planning meetings, data collection, analysis, writing, and travel. It also includes operating costs such as printing, advertising, and conducting meetings. Any contracts with community-based organizations or local governments for planning and coordination fall in this category, as do needs assessment projects to identify the scope and magnitude of the problem, resources available, gaps in services, and strategies to close the gaps.

Quality assurance: Includes activities to assure conformity to acceptable professional standards and identify problems that need to be remedied. These activities may occur at the State, substate, or program level. Substate administrative agency contracts to monitor service providers fall in this category, as do independent peer review activities.

Training (post-employment): Includes staff development and continuing education for personnel employed in local programs as well as support and coordination agencies, as long as the training relates to substance abuse services delivery. Typical costs include course fees, tuition, expense reimbursements to employees, trainers, and support staff salaries, and certification expenditures.

Education (pre-employment): Includes support for students and fellows in vocational, undergraduate, graduate, or postgraduate programs who have not yet begun working in substance abuse programs. Costs might include scholarship and fellowship stipends, instructor(s) and support staff salaries, and operating expenses.

Program Development: Includes consultation, technical assistance, and materials support to local providers and planning groups. Generally these activities are carried out by State- and substate-level agencies.

Research and Evaluation: Includes clinical trials, demonstration projects to test feasibility and effectiveness of a new approach, and program performance evaluation. These activities may have been carried out by the principal agency of the State or a contractor.

Information Systems: Includes collecting and analyzing treatment and prevention data to monitor performance and outcomes. These activities might be carried out by the principal agency of the State or a contractor.

6. **Substate entities receiving set-aside funds for prevention service delivery:** Describes the entities within the State (e.g., regions, schools, local health departments, colleges and universities) that receive 20% set-aside funds. The type and number of these entities is reported. If this differs dramatically by fiscal year, an estimate has been used and annotated in the report.

7. **Average amount of grant/contract:** Information on the average amount of funding expended by the substate providers compiled from information reported on Form 6 of the SAPT Block Grant application. Figures were derived by dividing the total amount of prevention funds expended by the State's prevention providers by the number of prevention contracts for each fiscal year.

8. **Per capita 20% set-aside spending (population):** Average amount of 20% set-aside funds spent per person within the State. These figures are derived by using U.S. Census Bureau estimates and projections for each year. The total amount of the set-aside allocated that fiscal year was divided by the U.S. Census figure for the State for that year.

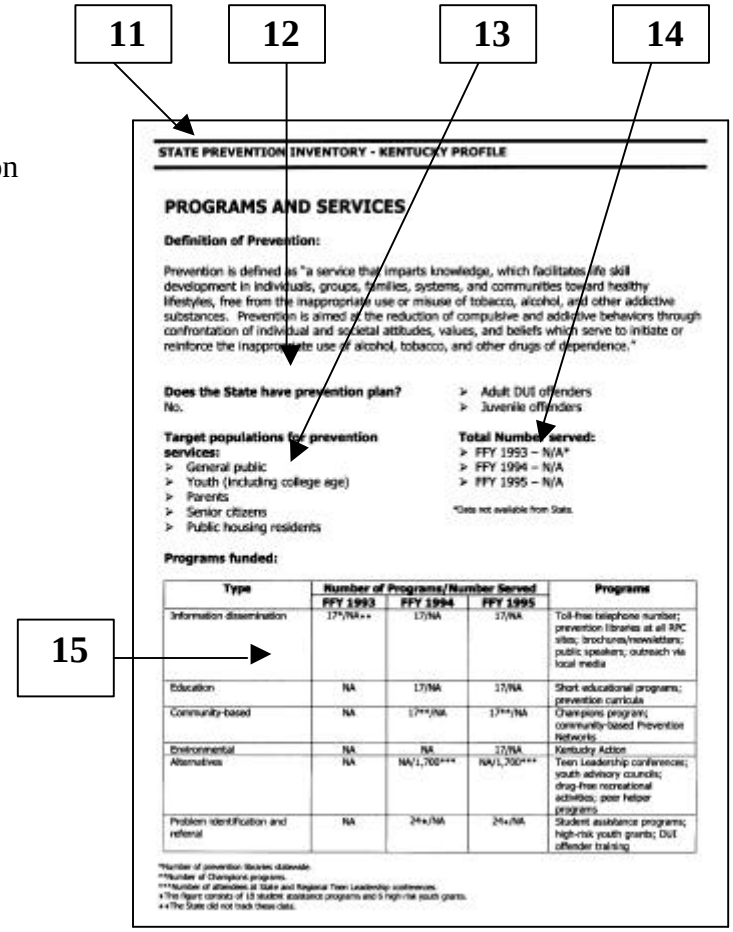
9. **Staff/Volunteers designated and supported by set-aside funding and level:** Details the number and type of staff supported by set-aside funding, including full-time and part-time staff and program volunteers at the State, regional, and local level. If this information varies dramatically by fiscal year, an estimate is used and annotated accordingly in the report.

10. **State Contact:** Name and contact information for the individual designated as the contact by the State AOD agency. If no contact was provided by the State, its National Prevention Network (NPN) designee has been used as the contact. This contact is meant to be a source for additional State-specific prevention information.

Section III – Programs and Services

11. **Definition of Prevention:** The definition of prevention that is used within each State for planning and implementation purposes. This definition may be different from the one supplied to SAMHSA and/or other government agencies for grant application purposes.

12. **State Prevention Plan:** Answers the question of whether the State has a prevention plan and includes details on the length of the plan, when it has been (or will be)

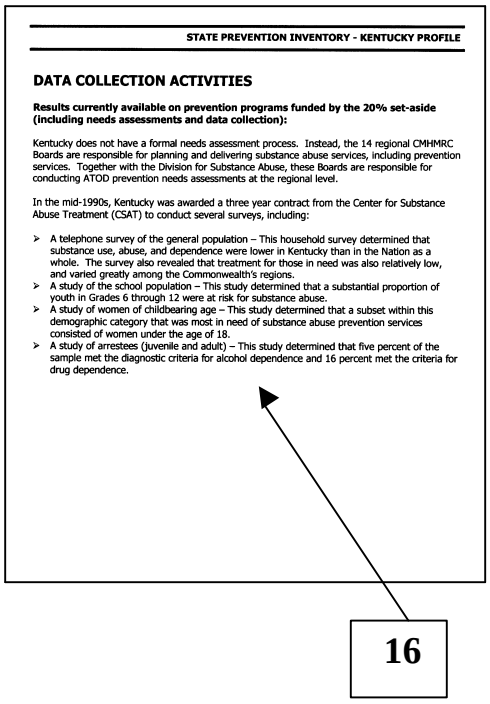


updated, and/or whether it is a stand-alone plan or part of a larger State health services plan.

13. **Target populations for Prevention Services:** Identifies the targets for primary prevention services funded, at least partially, by the 20% set-aside.

14. **Total Number Served:** These figures represent the total number of persons served by programs and services funded, at least partially, by the 20% set-aside. Unless otherwise specified, this will include the number directly served; if indirect service numbers are used, they are annotated accordingly.

15. **Programs Funded:** Provides detailed information on the types of programs, number of each type, and number of clients served (by type of program) for each of the three fiscal years. A sampling of actual programs under each type s also presented. Most States categorize their programs by CSAP strategy. Program types (e.g., parenting programs, youth leadership programs, coalition-building programs) reported in this document reflect the way in which each State classifies its programs.



STATE PREVENTION INVENTORY - KENTUCKY PROFILE

DATA COLLECTION ACTIVITIES

Results currently available on prevention programs funded by the 20% set-aside (including needs assessments and data collection):

Kentucky does not have a formal needs assessment process. Instead, the 14 regional CMHMRC Boards are responsible for planning and delivering substance abuse services, including prevention services. Together with the Division for Substance Abuse, these Boards are responsible for conducting ATOD prevention needs assessments at the regional level.

In the mid-1990s, Kentucky was awarded a three year contract from the Center for Substance Abuse Treatment (CSAT) to conduct several surveys, including:

- A telephone survey of the general population – This household survey determined that substance use, abuse, and dependence were lower in Kentucky than in the Nation as a whole. The survey also revealed that treatment for those in need was also relatively low, and varied greatly among the Commonwealth's regions.
- A study of the school population – This study determined that a substantial proportion of youth in Grades 6 through 12 were at risk for substance abuse.
- A study of women of childbearing age – This study determined that a subset within this demographic category that was most in need of substance abuse prevention services consisted of women under the age of 18.
- A study of arrestees (juvenile and adult) – This study determined that five percent of the sample met the diagnostic criteria for alcohol dependence and 16 percent met the criteria for drug dependence.

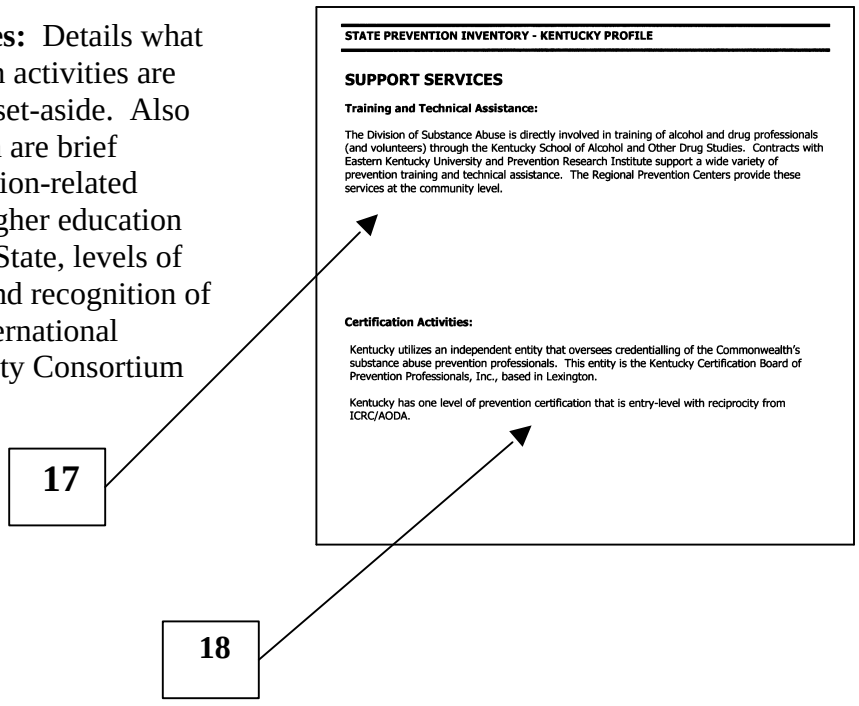
Section IV – Data Collection Activities

16. **Results currently available on prevention programs:** This section summarizes the States' data collection efforts for needs assessment, evaluation, and monitoring purposes. This section documents the available results on 20% set-aside-funded prevention programs. Also documented are needs assessments, evaluations, and other data collection activities performed by the State AOD Agencies that are funded – wholly or partially – by the 20% set-aside.

Section V – Support Services

17. **Training and technical Assistance:** This section details the types of training and technical assistance activities supported – either wholly or partially – by the 20% set-aside. Activities at the State and substate level are also noted.

18. **Certification Activities:** Details what prevention certification activities are supported by the 20% set-aside. Also included in this section are brief descriptions of prevention-related curricula offered by higher education institutions within the State, levels of certification offered, and recognition of certification by the International Certification Reciprocity Consortium (ICRC).



Aggregate Profile of State Prevention Activities

This section highlights key findings of the prevention service delivery system nationwide. Emergent themes and trends in the organization and structure, funding and resources, programs and services, data collection, and support services are provided with examples – where appropriate – of innovation at the State level (see the "Case Studies" section that immediately follows). Tables and figures are used to graphically illustrate specific data collected from each State.

Organization & Structure

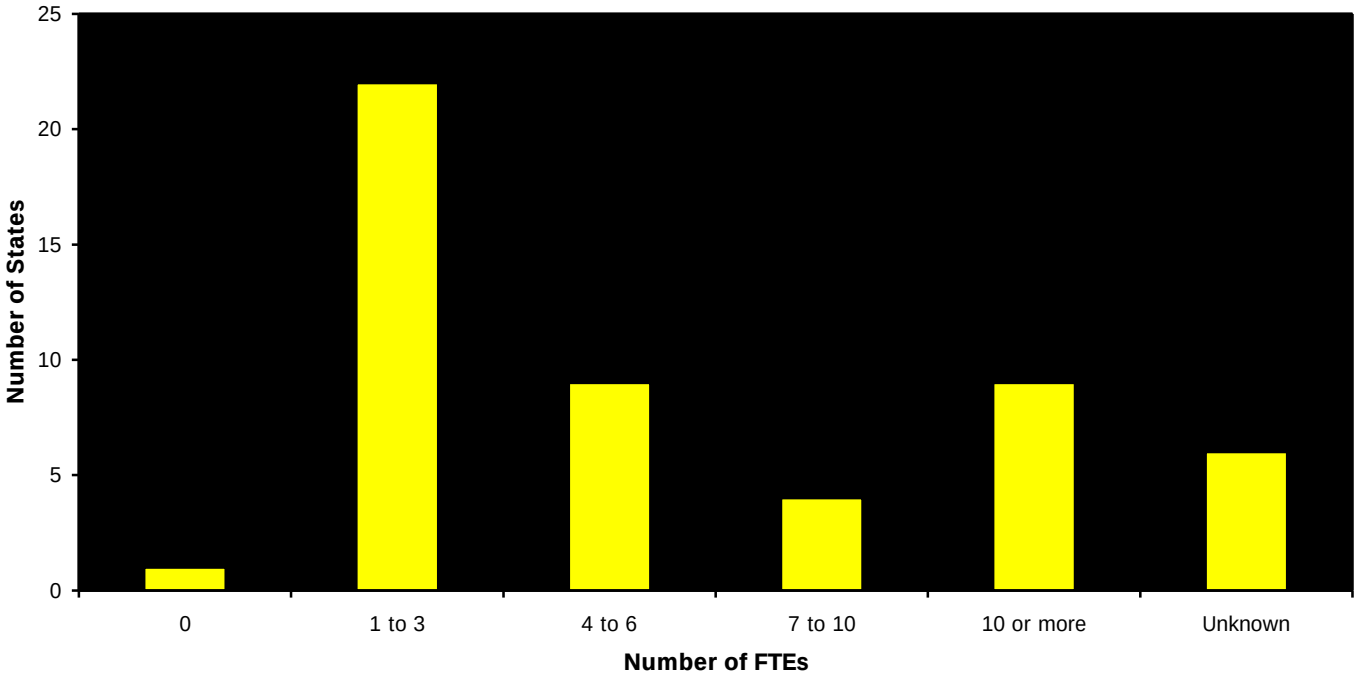
Typically, the Single State Authority (SSA) designated to receive and administer the Substance Abuse Prevention and Treatment (SAPT) Block Grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) within a given State is a division of an overarching Health Services or Social Services Department, the head of which often reports directly to the Governor. The SSA generally is a bureau or division that oversees all substance abuse services (including primary prevention activities) within the State. Four States – New York, Ohio, South Carolina, and Kentucky – managed their alcohol, tobacco, and other drug (ATOD) services at the cabinet level during FFY 1993-1995. Several smaller divisions generally comprise the SSA, one of which deals exclusively with prevention efforts. Regional or substate service agencies fall under the management of the Prevention Office or Division; each regional entity in turn oversees the efforts of the array of local provider agencies, community mental health centers (CMHCs), schools/universities, and so forth. Occasionally, a freestanding advisory panel, consisting of Governor-appointed individuals representing policy makers, educators, juvenile justice officials, and consumers, advises the SSA on relevant ATOD issues. These issues often include the establishment of funding priorities for ATOD programs, the appropriate allocation of ATOD funds, and policies concerning the distribution of ATOD-related data.

Four States – New York, Ohio, South Carolina, and Kentucky – manage their alcohol and other drug services at the cabinet level.

The administrative placement of the State ATOD agency does not appear to impact service delivery as much as the resources – both human and financial – that are available to deliver services. For example, State ATOD agencies that operate with one or two full-time equivalents (FTEs) were less able to provide technical assistance and support to substate entities providing prevention services. Conversely, States with five or more FTEs reported a direct role in the training and support of substate entities providing direct services. Figure 1 displays the number of prevention FTEs employed at the State level. These staff resources were often supplemented with volunteers at the local and regional level. However, only 16% (eight of the 51 States reporting) of State ATOD agencies were able to provide an actual count of the number of volunteers working at the State, regional, and local levels. These States noted that as few as 40 (Oklahoma) and as many as 23,500 (California) volunteers were engaged in prevention service delivery. States noted that the substate entities with whom they contracted

– as opposed to the SSAs themselves – were more likely to document the number of volunteers working on prevention activities.

Figure 1 – Prevention FTEs employed at the State level (FFY 1995) (includes District of Columbia).



State agencies work through substate entities.

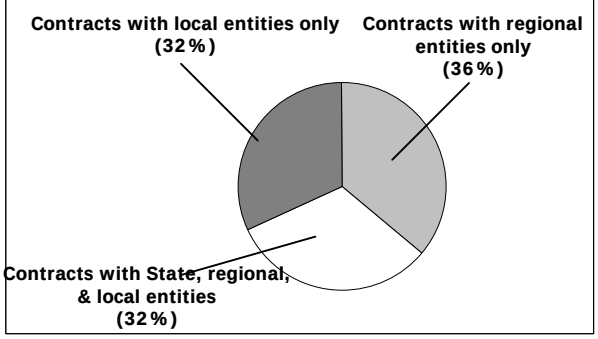
State ATOD agencies often work through substate entities. Substate prevention entities include geographically-determined planning districts, regional community mental health/mental retardation centers, public/private planning and action councils, regional State authorities, private non-profit organizations, colleges and universities, and tribal entities. The substate entities that receive funding from the State ATOD agencies maintain an important role in planning, implementing, and evaluating prevention programs. Our analysis found that States either:

- Contract exclusively with regional entities
- Contract exclusively with local entities
- Contract with a combination of State, regional, and local entities.

Thirty-six percent of all States reported that they contracted exclusively with regional entities to administer prevention programs. Many regional entities, comprised often of advisory boards and Governor-appointed councils, were portions of larger statewide coalitions and collaboratives advising the State ATOD agency on both prevention and

treatment issues. Thirty-two percent of all States reported that they contracted exclusively with community-based organizations to provide prevention services. These close ties with community-based organizations ensured that State-funded programming was being driven by communities and was relevant to their identified needs. Thirty-two percent of State agencies reported having a combination of contracting relationships with statewide, regional, and community entities. Essentially, the States themselves did not provide direct prevention services *per se*. Rather, statewide services such as Prevention Resource Centers, program development/evaluation, and youth leadership training were provided. Prevention Resource Centers remained one of the most common approaches for educating the public about the risks associated with drug use and for providing hands-on tools for parents, families, and communities to use in their prevention efforts with youth and other at-risk populations. Their accessibility, breadth of available information, and penetration appear to have contributed to this degree of success. Figure 2 displays the relative proportion of the different types of substate entities with which State agencies contract.

Figure 2 – Types of substate entities with which State agencies contract.



Populous States utilize a county-based prevention service delivery system

In general, the more populous States delegate much of the primary prevention decision making to the regional and local substate entities and providers. In New York, for example, the Bureau of Prevention and Intervention Policy contracts with local governmental agencies and community-based service provider agencies, all of which provide a continuum of statewide, regional, county, and community-focused ATOD prevention services. This Bureau oversees a prevention service delivery system that consists of approximately 450 school- and community-based prevention and early intervention programs that operate at over 2,700 sites throughout the State.

Prevention Resource Centers remained one of the most common approaches for educating the public about the risks associated with drug use.

Similarly, Pennsylvania and Ohio are allocated sizable appropriations from SAMHSA for carrying out primary prevention activities. Pennsylvania has a county-based prevention infrastructure in place, consisting of 49 Single County Authorities (SCAs) that manage and deliver prevention, intervention, and treatment services throughout the Commonwealth's 67 counties. Although the SCAs are given broad latitude in the provision of culturally relevant prevention strategies, the Bureau of Drug and Alcohol Programs (the SSA) oversees a performance-based system that utilizes researched methodologies for reducing

Typically, the more populous States delegate much of the primary prevention decision making to the regional and local substate entities and providers.

substance abuse risk factors. In Ohio, the Department of Alcohol and Drug Addiction Services oversees 50 Community Boards that determine prevention needs, plan services, and contract with providers at the local level. These Community Boards, which are units of county governments, are organized by the State into metropolitan *versus* rural regions.

Perhaps no other State illustrates more clearly the pivotal role of county-based ATOD prevention service delivery than California. With a 1995 estimated population of 31,589,000 (one in eight Americans is a California resident), the California Department of Alcohol and Drug Programs provides statewide leadership, technical assistance, demonstration projects, and resource development to local substance abuse programs through its Prevention Services Division. The majority of SAPT prevention funds are allocated to the State's 58 counties, which are given the responsibility to determine how these funds will best meet the needs within their local jurisdictions. Therefore, the majority of prevention programming occurs at the local level, with each county conducting its own needs assessments based on population size, rural *versus* urban demographics, and the types of substances used.

In California, the majority of prevention programming occurs at the local level, with each county conducting its own needs assessments based on population size . . . and the types of substances used.

The challenges of the frontier States

In contrast to the Nation's most populous States, unique challenges in prevention service delivery face the so-called "frontier" States. ("Frontier" describes a State in which there are fewer than six residents per square mile in at least 50% of the State's counties.) States such as Alaska, Nevada, Montana, Wyoming, New Mexico, and the Dakotas must devise unique service delivery systems that satisfy the specific needs of their residents, including Native American populations. Issues faced by the frontier States in the provision of prevention services include the following:

- Lack of access
- Limited resources
- Uneven data collection
- Higher rates of ATOD risk factors

Issues related to access pose a major challenge for the frontier States. Chief among these is inadequate transportation. Transportation is often a daunting problem in these States, with geographically-isolated population centers that make the provision of direct service delivery to consumers quite difficult. Public transportation – when existent – is often confined to the State's largest city or town. Other barriers to adequate access to statewide prevention systems include language

The frontier States . . . must devise unique service delivery systems that satisfy the specific needs of their residents. . . .

competency and the lack of adequate health insurance. In these predominantly rural areas, it is often not possible to develop a complete continuum of care in all but the largest communities.

For those frontier States that capture prevention-related data, the data collection process can at times be uneven. Under-reporting and assurances of confidentiality are issues cited by these States, and these issues are especially evident among the Hispanic and Native American populations.[1] Distortions in drug-related statistics may arise among these ethnic and cultural minorities, especially when census data are used. AOD abuse rates based on census data may be inflated due to undercounting of Hispanic and Native American youth, and census data may not account for some illegal immigrants. While other data exist on drug abuse among American Indians in general, there are approximately 200 American Indian tribes for which almost no specific data exist, according to the National Institute on Drug Abuse (NIDA).

On the average, risk factors for ATOD abuse are higher in the most rural counties of the frontier States. For example, according to a recent social indicator data study in New Mexico, rural counties have – in general – the highest rates of high school dropout, unemployment, Medicaid-funded births, and liquor licenses. The frontier States recognize the need to establish comprehensive prevention strategies – including the development of more alternative activities for at-risk youth – in these areas, but the ability to effectively do so is often constricted by the lack of resources.

Funding & Resources

This section provides an aggregate profile of the States' utilization of the 20% prevention set-aside, especially in terms of the strategy areas identified by the Center for Substance Abuse Prevention (CSAP).

Allocations of Block Grant components

The Public Health Service Act and its implementing regulations mandate that portions of each SAPT Block Grant be expended for specific purposes. In FFY 1993-1995, these required expenditures included:

35% Alcohol-related activities
35% Other drug-related activities
20% Prevention
10% Treatment services for pregnant women and women with dependent children
2-5% Early intervention services for HIV-positive clients[2,3]

This section focuses on the 20% prevention set-aside and the aggregate spending patterns of the States.

Block Grant, 20% set-aside, and State expenditures – In Federal Fiscal Years (FFY) 1993-1995, the primary prevention set-aside total for States increased from $234.8 million in FFY 1993 to $255.9 million in FFY 1995, an increase of 9%.[4] Adjusting for inflation, this increase in spending was 3%, in constant 1993 dollars.[5]

Some States chose to spend above-and-beyond the Federally-mandated 20% set-aside on primary prevention activities. A notable example was New York State, which spent substantially more of the SAPT award on primary prevention than was required to meet the 20% set-aside mandate. In FFY 1994-1995, the State spent (on average) 23% more on primary prevention than was required by law.

In Federal Fiscal Years 1993-1995, the primary prevention set-aside increased from $234.8 million to $255.9 million, an increase of 9%.

Of the 51 States analyzed in this report (50 States plus the District of Columbia), 33-41 States (depending on the year) expended fiscal resources for prevention activities from State general funds. These supplemental State expenditures totaled $116 million, $156 million, and $133 million in Federal Fiscal Years 1993, 1994, and 1995, respectively.

The accompanying Table 1 displays the average Block Grant expenditures for FFY 1993-1995, the average amounts spent on primary prevention from the Federal allocation, and the average amount spent that was derived from State funding.

Table 1 – Average Block Grant Expenditures on Primary Prevention Activities, FFY 1993-1995.

Year (FFY)	State Expenditures (N=51)[6]	SAPT Expenditures (N=51)	20% Set-aside (N=51)
1993	$2,316,851	$20,219,951	$4,603,696
1994	$3,049,883	$21,388,157	$4,669,993
1995	$2,632,540	$22,614,405	$5,018,110

Table 2 summarizes Block Grant, set-aside, and State funding for prevention-related activities for each of the 50 States and the District of Columbia (FFY 1993-1995). In this three-year period, a total of $728,881,795 was expended for prevention activities from the SAPT Block Grant. This was supplemented by a total of $404,384,015 from State funding sources (see Figure 3 at right). The largest Federal prevention set-aside expenditures took place in

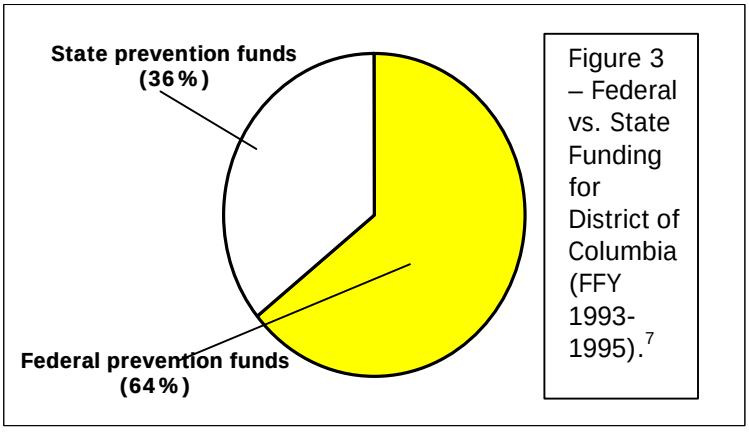


Figure 3 – Federal vs. State Funding for District of Columbia (FFY 1993-1995).[7]

California, while New York spent the most State funds on primary prevention.

Funding allocated by CSAP Strategy Area – Most States maintain prevention programs that are aligned with the six strategy areas of information dissemination, education, problem identification and referral, alternatives, environmental, and community-based process(es), as defined by CSAP. A few States utilize variations of the Federally-defined strategies, but the specific programs that are offered within these strategies resemble those offered by the majority of States.[8] The six CSAP prevention strategies are:

- Information dissemination – Programs in this category provide awareness and knowledge on the nature and extent of substance use, abuse, and addiction. Knowledge and awareness of available prevention programs and services is heightened. The exchange of information involves a one-way communication from the source to the audience. Examples of these activities include statewide clearinghouses or information resource centers, media campaigns, health fairs, and radio/television public service announcements.

- Education – Programs in this category are meant to affect critical life and social skills, such as decision making, refusal skills, and critical analysis. Two-way communication is emphasized between the educator/facilitator and the program participants. Examples of these activities include classroom sessions, parenting and family management classes, and peer leader/helper programs.

- Alternatives – Prevention activities allow participants to engage in structured activities that exclude alcohol, tobacco, and other drug use. The underlying assumption of these programs is that constructive and healthy activities offset the attraction to, or otherwise meet the needs usually filled by alcohol, tobacco, and other drugs. Examples of such activities include community drop-in centers, drug-free dances/parties, and youth/adult leadership activities.

- Problem identification and referral – Programs in this prevention category aim to identify those individuals who have indulged in illegal or age-inappropriate use of tobacco or alcohol in order to assess if their behavior can be reversed through education. Activities in this area include student assistance programs, employee assistance programs, and DUI education programs.

- Community-based process – These prevention programs aim to enhance the ability of the community to more effectively provide prevention and treatment services for alcohol, tobacco, and drug abuse disorders. Organizing, planning, enhancing efficiency and effectiveness, collaboration, coalition building, networking, and training are prime methodologies within this category. Examples of programs include community and volunteer training, multi-agency coordination and collaboration, and community team building.

- Environmental – This category seeks to establish changes in written and unwritten community standards, codes and attitudes, thereby influencing incidence and prevalence

of the abuse of alcohol, tobacco, and other drugs used in the general population. Examples of relevant programs include promoting the establishment and/or review of ATOD use policies in schools, technical assistance to communities to maximize law enforcement procedures governing the availability and distribution of ATOD, and modifying advertising practices.

- Other – This category is designed to capture spending outside the six prevention strategies. Expenditures in this category may include Section 1926 (i.e., Synar Amendment compliance); the hiring of contractors to provide specific technical assistance; resource development activities, such as quality assurance, research/evaluation, and information systems (this is described in greater detail below); and other primary prevention activities that can not be classified under the six prevention strategies.

Table 2 – Prevention Expenditures by State Under the SAPT Block Grant and State Prevention Expenditures that Flow Through the State's Substance Abuse Agency, FFY 1993-1995.*

State	FFY 1993			FFY 1994			FFY 1995		
	State Expenditure	SAPT Expenditure	20% Set-Aside	State Expenditure	SAPT Expenditure	20% Set-Aside	State Expenditure	SAPT Expenditure	20% Set-Aside
Alabama	$0	$12,398,438	$2,479,688	$0	$13,064,586	$2,616,678	$0	16,533,558	$3,306,711
Alaska	744,445	2,170,796	434,159	744,445	2,170,796	434,159	937,765	1,716,152	562,560
Arizona	103,227	15,366,146	3,743,309	156,746	16,034,641	3,725,809	156,746	18,191,233	3,725,809
Arkansas**	75,000	5,738,000	1,149,000	0	7,450,981	1,490,196	0	8,250,119	1,650,024
California	N/A	152,246,288	39,382,514	13,634,390	158,842,557	31,768,511	12,246,618	164,135,903	34,327,180
Colorado	332,242	14,417,044	3,018,230	354,325	15,732,350	3,164,161	193,259	17,784,752	3,728,088
Connecticut	2,285,304	13,855,083	2,791,252	2,521,956	13,855,083	2,813,745	3,030,305	13,401,696	2,671,128
Delaware	153,258	3,205,135	633,068	639,027	3,333,343	661,724	835,489	3,296,534	702,951
D.C.	969,262	3,887,424	777,485	1,139,378	3,881,314	786,303	728,077	2,899,748	585,442
Florida**	10,257,649	50,095,842	10,019,168	0	50,095,842	9,922,178	1,234,447	49,150,388	9,756,766
Georgia	49,348	21,753,003	4,622,719	850,696	23,619,081	4,721,422	0	26,669,566	5,369,826
Hawaii**	0	5,229,117	1,193,012	0	5,466,866	1,176,386	0	5,583,494	1,254,683
Idaho**	0	3,472,482	875,924	0	4,348,294	877,613	0	4,341,003	870,258
Illinois	4,011,675	45,973,846	8,193,884	5,475,504	51,292,265	11,080,004	10,879,100	53,633,438	15,966,826
Indiana**	0	18,680,253	3,704,102	0	20,635,226	4,102,604	0	28,984,430	5,820,585
Iowa	1,041,369	9,769,497	2,086,637	1,140,977	10,315,738	2,192,118	1,567,421	11,190,416	2,372,508
Kansas	585,000	7,839,769	1,567,953	751,538	9,485,528	2,587,134	861,925	9,722,322	2,027,610
Kentucky	493,241	13,095,961	3,105,591	677,027	14,568,397	3,060,965	536,505	15,288,733	3,262,593
Louisiana**	89,999	17,581,345	3,253,337	0	18,773,887	3,778,495	0	20,189,276	4,077,443
Maine	820,635	3,809,162	818,230	417,965	3,800,006	765,945	729,285	4,798,475	1,123,071
Maryland	0	22,226,451	6,254,532	0	22,989,174	6,007,691	0	24,271,345	6,019,433
Massachusetts	1,338,000	26,080,000	6,003,000	1,296,000	26,080,000	6,463,000	1,370,000	29,894,000	6,661,000
Michigan	5,447,230	43,664,626	9,713,984	5,447,230	46,177,047	10,133,144	3,890,553	48,701,101	10,687,025
Minnesota	3,629,305	16,076,460	3,758,589	1,372,474	17,325,488	3,470,833	1,380,000	18,479,218	3,866,920
Mississippi	0	7,124,951	1,484,494	0	7,807,911	1,568,070	0	9,825,619	1,965,123
Missouri	29,999	18,224,260	3,644,851	29,045	18,487,928	3,779,841	29,762	20,651,348	4,132,051
Montana**	0	2,494,122	501,193	0	2,927,594	594,080	0	3,376,780	675,356
Nebraska	771,014	4,779,695	1,223,819	772,390	5,353,672	1,070,735	767,864	5,281,685	1,056,337
Nevada	42,000	5,538,937	1,158,521	42,000	5,679,574	1,181,555	42,000	6,316,824	1,274,364
New Hampshire	606,682	2,635,804	527,161	0	3,681,986	736,397	0	4,438,226	887,645
New Jersey	84,275	37,274,956	7,777,895	305,551	37,380,258	7,558,782	271,542	35,208,769	8,539,335
New Mexico	2,491,500	4,604,330	940,464	3,177,028	5,621,023	1,133,689	3,524,293	5,805,151	1,161,030
New York	49,355,937	89,990,049	18,824,884	53,576,089	90,018,218	22,122,952	45,127,991	84,711,286	20,864,782
North Carolina	275,000	23,342,026	4,675,521	6,549,911	24,899,540	5,640,091	0	25,959,431	6,774,913
North Dakota	10,849	1,959,354	411,000	6,210	2,185,727	438,171	1,143	2,163,733	432,746
Ohio	3,335,372	45,208,396	10,257,925	5,235,040	53,151,494	12,188,370	6,053,041	55,310,231	13,131,564
Oklahoma	73,337	10,799,407	2,159,881	28,762	12,784,280	2,556,844	226,443	13,286,731	2,657,346
Oregon	4,600	11,210,572	2,363,297	48,277	12,550,659	2,512,033	27,664	13,144,267	3,113,059
Pennsylvania	6,033,073	49,068,046	10,316,395	7,354,170	49,158,719	12,037,132	7,331,516	52,546,450	10,509,533
Rhode Island	3,402,535	4,952,784	1,113,423	3,044,795	5,824,724	1,311,678	3,045,973	4,486,642	904,681
South Carolina**	0	12,830,000	2,872,000	0	14,053,850	2,844,460	0	14,472,835	2,909,886
South Dakota	0	1,887,213	417,486	0	2,435,929	606,219	0	2,054,868	414,223
Tennessee	1,863,970	15,342,804	3,792,717	1,858,537	16,883,598	3,861,668	2,021,166	19,018,923	4,551,884
Texas	2,773,172	70,164,549	22,987,135	19,840,661	72,088,225	18,109,928	6,100,534	80,986,252	18,540,021
Utah	1,893,776	8,500,272	1,818,517	1,498,231	8,562,656	1,975,994	1,895,705	9,783,755	2,163,909
Vermont	360,218	1,900,825	381,456	267,957	1,960,825	440,165	316,063	2,428,248	485,650
Virginia	2,413,537	24,233,472	4,858,451	5,762,033	25,632,420	5,178,144	6,196,651	28,854,552	5,835,702
Washington	3,280,644	23,188,841	4,889,709	5,208,993	24,807,591	5,148,990	6,384,000	25,283,792	6,215,869
West Virginia	0	5,393,862	1,120,868	0	5,981,377	1,251,993	0	7,591,586	1,573,314
Wisconsin	3,939,921	18,674,361	4,421,780	3,939,921	19,956,963	4,192,600	3,939,921	21,838,831	4,441,882
Wyoming	374,934	1,261,466	268,302	378,773	1,580,789	467,212	378,773	1,400,924	314,970
Total	115,842,534	1,031,217,522	234,788,512	155,544,052	1,090,796,020	238,308,611	134,259,540	1,153,334,639	255,923,615

*Includes District of Columbia.

** State expenditures are the amounts reported by each State on Form 4 of the SAPT Block Grant application. Consistent with the instructions for this form, States only report expenditures of State-derived funds *which flow through the State's substance abuse agency*. Further analysis revealed that although the State substance abuse agency did not expend State-derived funds on prevention, funds were indeed expended through other State agencies. Please refer to the individual State profile for a detailed explanation.

Average expenditures by all 51 States for primary prevention activities in each strategy area are presented in Table 3. As Table 3 indicates, the largest average expenditures occurred in the prevention strategy areas of "Education" and "Information Dissemination." Prevention Resource Centers were but one tool utilized by the States in these two strategy areas. Figure 4 below shows graphically the proportion of funds allocated to each of these strategy areas in FFY 1995.

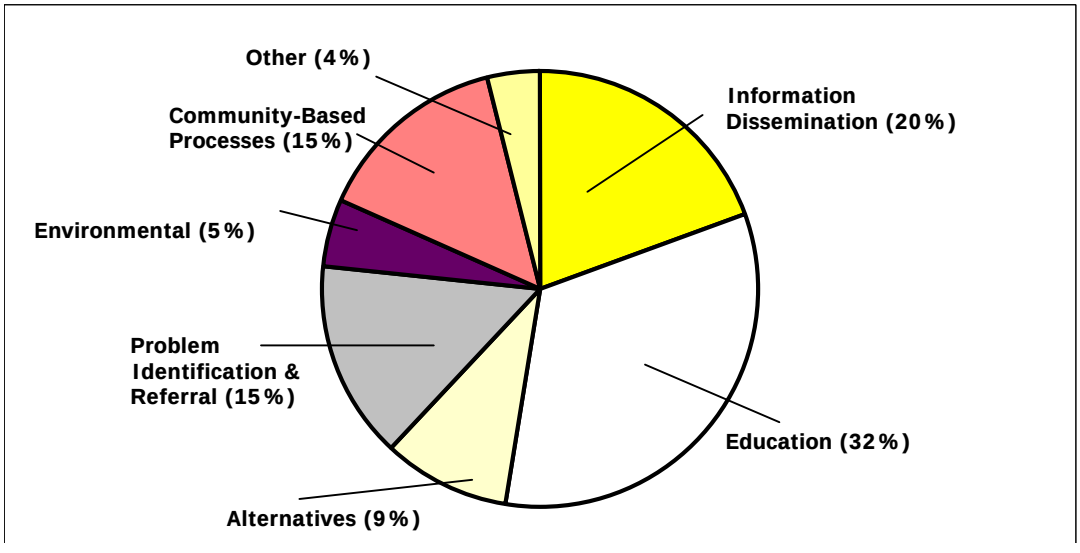
Because the six CSAP prevention strategies were introduced midway through FFY 1993, only 45 States (out of a total of 51) were able to report fiscal expenditures categorically, as Table 3 indicates. However, in FFY 1994-1995, all States (including the District of Columbia) were able to report prevention expenditures in the six strategy areas.[9]

Table 3 – Average Expenditures, by CSAP Strategy Area, FFY 1993-1995.

CSAP Strategy	FFY 1993 (N=45)	FFY 1994 (N=51)	FFY 1995 (N=51)
Information Dissemination	$829,140	$912,848	$981,362
Education	$1,397,154	$1,563,606	$1,685,127
Alternatives	$547,740	$408,854	$477,960
Problem Identification and Referral	$668,908	$683,617	$744,925
Environmental	$239,421	$245,888	$217,139
Community-Based Processes	$517,342	$664,543	$697,626
Other	$178,497	$190,638	$205,051

Resource development – Many States utilized a portion of their Federal Block Grant set-aside allocations for prevention "resource development" activities such as planning, coordination, needs assessment, quality assurance, training of counselors, program

Figure 4 – Percentage of Federal Prevention Set-Aside Funds Expended to Each of the CSAP



Strategy Categories (FFY 1995).

development, research and development, and information systems development. In submitting their Block Grant applications, States were given the option of itemizing their resource development-related expenditures in accordance with the categories listed in Table 4 below. Some, but not all, States chose to include this information in their Block Grant applications and distinguished between funds allocated for treatment activities and funds allocated for prevention activities. For States reporting such estimates, these aggregate data are presented in Table 4 below.

Table 4 – Average State Expenditures on Substance Abuse Resource Development Activities, FFY 1993-1995 (includes District of Columbia).

Resource development area	FFY 1993 (N=40)	FFY 1994 (N=46)	FFY 1995 (N=36)
Planning, coordination, and needs assessment	$131,702	$68,964	$56,636
Quality assurance	$122,599	$99,410	$35,428
Training (post-employment)	$80,091	$58,228	$65,685
Education (pre-employment)	$89,326	$11,071	$69,964
Program development	$84,252	$94,102	$97,557
Research and evaluation	$38,399	$34,278	$79,422
Information systems	$28,608	$41,913	$29,360

As Table 4 indicates, the amount of the Federal Block Grant set-aside allocation expended for prevention resource development activities such as planning, coordination, needs assessment, quality assurance, counselor training, program development, research and development, and information systems development varied widely at the State level. The highest expenditures were in the areas of planning/coordination/needs assessment and quality assurance.

It should be noted that the reporting of information on resource development activities was only intended to provide the Federal government with a sense of a particular State's commitment to such activities. Such activities may have been funded – wholly or partially – by the 20% set-aside. Therefore, the amounts entered in this optional table do not necessarily reconcile with the data displayed in the other funding and resource tables presented in the individual State profiles. In addition, it should be noted that the data provided by the States for this category represented estimates, as opposed to actual expenditures.

Substate entities receiving set-aside funds – The vast majority of the 51 States analyzed maintain a regional, "substate" organization within the overall prevention infrastructure. This substate organization often consists of a regionally- or geographically-based array of prevention offices. Our studies revealed that some States maintained an urban/rural dichotomy (e.g., Nevada, Ohio), others had large, multi-county regions (e.g., Nebraska), and still others utilized a county-based prevention infrastructure (e.g., South Carolina, Pennsylvania).

Substate entities that received Federal set-aside funds included regional planning districts, community mental health/mental retardation centers, public/private planning and action councils, regional State authorities, private non-profit organizations, colleges and universities, and tribal entities.

Average amount of grant/contract – In FFY 1993-1995, States awarded grants or contracts to local providers for the provision of primary substance abuse prevention services. These contracts were awarded through either a competitive request for proposals (RFP) process, or via non-competitive means. Average amounts for State-awarded grants or contracts are displayed in Table 5 below.

Per capita 20% set-aside spending – Per capita spending ranged from $0.49 (North Dakota, FFY 1993) to $1.28 (Texas, FFY 1993). Average per capita spending for all States is summarized in Table 6 below.

Table 5 – Average amounts of grants/contracts allocated to substate entities or local providers, FFY 1993-1995.

Year (FFY)	Amount
1993	$84,864 (N=49)
1994	$91,443 (N=51)
1995	$87,383 (N=43)

Table 6 – Average 20% prevention set-aside spending per capita, FFY 1993-1995.

Year (FFY)	Per capita amount
1993	$0.80 (N=51)
1994	$0.85 (N=51)
1995	$0.88 (N=51)

Other funding streams used for prevention

The individual State profiles contained in this document display information on substance abuse prevention programs that are funded, either wholly or partially, by the 20% SAPT Block Grant set-aside. Although some States used the Federal set-aside to exclusively fund their prevention activities (e.g., Alabama, Indiana, South Dakota), others blended several funding streams to underwrite their prevention services. Examples of additional funding streams include:

- Safe and Drug-Free Schools and Communities Block Grant
- Specific contracts from CSAP or CSAT (usually to hire a contractor to help the State conduct needs assessments)
- State general funds
- Liquor sale license fees

Programs & Services

The task of prevention, intervention, and treatment of substance use and abuse programs is of major significance at the Federal, State, and local level. It must be emphasized that there is no single answer or design for this task but there exists a whole host of programs that are successful in identifying, intervening, and treating "at risk" or "high risk" populations. "That lesson is clear and simple: no *single* tactic – pursued alone or to the detriment of other possible and valuable initiatives – can work to contain or reduce drug use."[10]

There are certain criteria that are seen as necessary components that programs need to incorporate in order to fulfill the mandate of creating community-based prevention and intervention models. Most successful models contain the following criteria:

- Comprehensive in nature – Systems that use multiple approaches, diverse and multi-discipline staff, utilize creative modalities (traditional to expansive models) are part of or are integrated into community mental health systems.

- Target multiple sectors of the community – Service schools, parents, civic organizations, minorities, businesses, housing projects as dictated by a systems approach to prevention and intervention.

- Incorporate multiple activities – Include assessment, counseling, multi-modality approaches, prevention/education, tutoring, recreational therapies, vocational assessment and work related activities, specialized health and population needs.

- Address the needs of multiple target populations. – Provide services to youth, students, youthful offenders, parents, adults, minorities, the elderly.

- Develop interrelated and collaborative systems – These systems include all segments of the community: families, schools, criminal justice, law enforcement, medical rehabilitative, business, civic, governmental. Board members, advisory councils, volunteers, as well as formalized affiliations, referral systems, and interdisciplinary case conferences, staff meetings are utilized in order to establish an integrated approach to service these populations.

- Maintain community involvement and foster community "ownership" of the program components – Involvement, empowerment, and ownership to enhance grassroots movements as they respond to unique neighborhoods or community needs; success is

more likely by working *with* specific clients rather than superimposing education *upon* them.

- Long term commitment to developing, testing, refining, and disseminating effective technologies that impact clients, systems, and communities – Emphasis must be placed on *evaluation* and *assessment* of program delivery, methodologies to determine program outcomes that impact attitudes, resistance skills, choices, and behaviors with regard to use and abuse of substances.

- Empirically-based planning for selecting and developing program strategies and implementation – Conducting a review of existing programming through utilization of existing research, literature, and program review by tapping into the Federal governmental, State systems and authorities for successful proven programs in the prevention, intervention, and treatment of "at risk" and "high risk" populations.[11]

Definition of prevention – There appears to be a consensus among the 51 States that were examined in defining prevention. Virtually all States have a formal definition of prevention that incorporates many of these tenets:

- Prevention is a proactive process.
- Prevention programs should enhance protective factors and reduce risk factors.
- Prevention efforts are focused on the individual, the family, and the community.
- Prevention services should preclude the onset of substance use/abuse in the general population.
- Prevention services should prevent the progression of early-stage substance abuse in individuals currently using substances.

The emphasis of prevention initiatives is on the individual's physical and psychosocial makeup.

Target populations – Our analysis revealed that over three-quarters of the States targeted their primary substance abuse prevention services at middle- and secondary-school students, as well as college-aged young adults. Youth-based target populations also consisted of children of substance abusers, homeless/runaway youth, youth in the criminal justice population, and youth at high risk for gang violence. The most common target populations identified by the States (and the percentage of States that targeted each particular group) were as follows:

- Middle- and secondary-school students, and college students (78%).
- Substance abusing women of childbearing age (43%).
- Ethnic/racial minorities (35%).
- Children of substance abusers (25%).
- Elderly (25%).

Other targeted populations included adults in the criminal justice system, school drop-outs, HIV-positive individuals, and gay/lesbian individuals. Several States indicated that their prevention programs targeted all citizens of the State.

Programs offered – CSAP, in conjunction with State representatives, developed a classification system identifying six prevention strategies that serve as a basis for planning prevention programs. (The strategies are described in the "Funding and Resources" section.) Our studies revealed that common programs included Prevention Resource Centers, school-based educational programs, information clearinghouses, media campaigns, and community-based coalitions and partnerships. Specific prevention programs and strategies are highlighted in the "Case Studies" section that immediately follows.

Data Collection

Prior to 1994, only a minority of the States had the capacity to conduct comprehensive statewide needs assessments and/or to design complex management information systems for reporting prevention data. Over the past four years, prevention data collection has improved and enhanced the way in which States do prevention program planning by providing results of needs assessments and evaluation activities. Our analysis revealed that only two States had no prevention-specific data system in place (at the time of publication). Many States have developed and implemented prevention management information systems (MIS), including Arizona, whose MIS is linked to all funded providers.

Needs assessment continues to be an important focus of State efforts

Our studies indicated that all 51 States fall within a continuum in their methods of capturing prevention-specific data:

- States conduct needs assessments at the State or substate level.
- States utilize outcomes-based contract monitoring.
- States utilize existing (or archival) data repositories.
- In some States, plans are underway to develop or implement such a system.
- In a few States, no data system is in place, nor are plans underway to create one.

Most States conducted prevention needs assessments at either the State or substate levels, as Figure 5 indicates.[12]

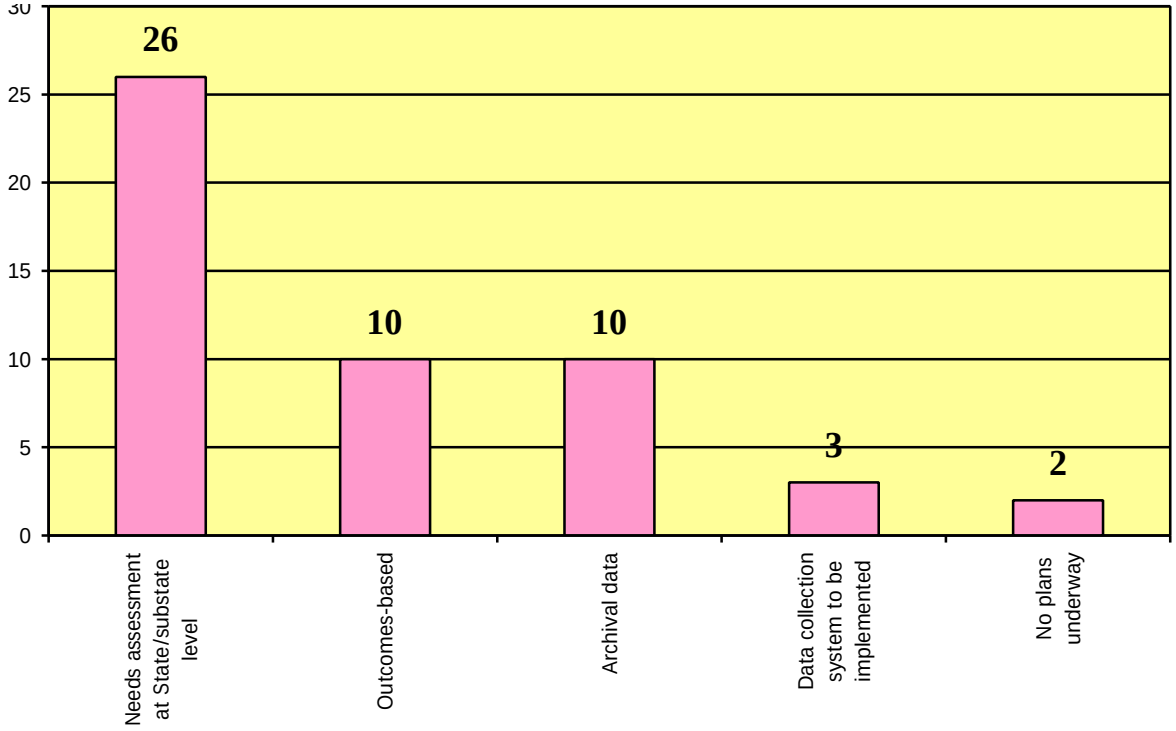
Figure 5 – Prevention-Specific Data Collection by the States (including District of Columbia).

Support Services

Training and technical assistance

Of the 51 states surveyed, 18 indicated that they utilized set-aside funds for prevention-related training and/or technical assistance. Mechanisms of expenditures were quite diverse, ranging from the State to the local level.

Some States provide training or technical assistance at the level of the SSA. In Maryland, the Alcohol and Drug Abuse Administration provides technical assistance to its regional statewide prevention centers. In Ohio, the SSA utilizes set-aside funds to underwrite major training conferences, such as the Ohio Alcohol and Drug Addiction Studies Institute. In contrast, States such as Arkansas, Illinois, and Indiana, encourage the use of training/technical assistance workshops by their regional Prevention Resource Centers. These Prevention Resource Centers are supported by the Block Grant set-aside. Iowa utilizes its Federal set-aside to contract with the Iowa Substance Abuse Program Director's Association to deliver culturally competent training to the State's substance abuse prevention and treatment providers. In Wyoming, set-aside funds are used to support a Prevention Generalist Training course, which is offered to individuals employed in community programs who provide prevention services.



One State in particular – Connecticut – utilizes its prevention set-aside to support a wide array of training/technical assistance activities. This training occurs through The CENTER, a component of the State's prevention system that offers comprehensive, state-of-the-art training for professionals and volunteers. Training has been provided in topics that include drug-free workplaces and campuses, practical applications for results mapping, street work with high-risk youth, and the achievement of cultural competence.

Arkansas, Illinois, and Indiana encourage the use of training/technical assistance workshops by their regional Prevention Resource Centers.

Certification

None of the 51 States analyzed for this report utilize Federal Block Grant set-aside funds to underwrite certification-related activities for their prevention specialists. Nearly 60% of the States (31/51) require their prevention professionals to be certified. Of those that do have this requirement in place, an independent State certification board is used. At least ten of these State Boards participate in the International Certification Reciprocity Consortium (ICRC). The ICRC is an international organization comprised of member boards that offer credentialling to professionals engaged in the prevention and treatment of substance abuse addictions and related disorders. The ICRC's mission is to establish, monitor, and advance reciprocal competency standards for AOD counselors, prevention specialists, and clinical supervisors.

The majority of the States with certification processes do support the certification process by offering a variety of ongoing training opportunities in preparation for and/or for

maintenance of the prevention credential. For example, prevention-related curricula are presently offered at educational institutions in two States: the University of Oklahoma and the University of South Dakota. A prevention curriculum is in development at the University of New Mexico.

None of the 51 States surveyed for this report utilize Federal Block Grant set-aside funds to underwrite certification-related activities for their prevention specialists.

Some States offer various tiers of prevention certification, depending on the professional's level of experience. In Arkansas and Ohio, for instance, accredited levels include a "certified prevention specialist" and a "certified prevention consultant." The specialist level involves direct client contact, and the professional must be able to provide knowledge and skills to prevent the misuse/abuse of ATOD. The professional may be involved in delivering school-based prevention curricula, facilitating youth and community groups, and so on. Accreditation for the consultant tier of prevention service delivery involves proficiency in a broad spectrum of prevention services (e.g., coordination, advising, planning, administration, etc.). Such individuals would be expected to design and supervise prevention programs, and ensure that such programs impart the knowledge and skills needed by clients to promote the development of healthy behaviors.

Endnotes

1 According to a member of the Prevention Unit in New Mexico, confidentiality issues among these populations may preclude the accurate reporting of risk factors.

2 In addition, the SAPT Block Grant requires designated States to use between 2-5% of their allotments on early intervention services for HIV-positive clients. "Designated" States are defined as those with an incidence of acquired immune deficiency syndrome (AIDS) of 10 or more per 100,000 residents.

3 States are required to enact and enforce State laws prohibiting the sale and distribution of tobacco products to minors. Penalties of up to 40% of the State's SAPT Block Grant allocation may be levied if this compliance is not met. No funding in the SAPT Block Grant is provided to meet the Synar provision.

4 Unless otherwise indicated, all financial data for Federal Fiscal Years 1993, 1994, and 1995, are expenditures reported in the FFY 1996, 1997, and 1998 Block Grant applications, respectively.

5 The inflation rates for 1994 and 1995 were 2.6% and 2.8%, respectively. The methodology for this calculation is as follows:

Year	Inflation Rate	Prevention Amount (in millions)	Calculation	Prevention Amount (in constant 1993 dollars)
1993	---	234.8	----------	234.8
1994	2.6%	238.3	238.3-(238.3)(0.026)=232.1	232.1
1995	2.8%	255.9	255.9-(255.9)(0.028)=248.7; 248.7-(248.7)(0.026)=242.2	242.2

6 For the purposes of this Inventory, profiles were assembled for the 50 States and the District of Columbia.

7 State-reported expenditure amounts may in some cases vary from the amount allocated to the State by SAMHSA due to a number of factors, some of which may include: (1) the State spent less than the amount allocated to it, (2) the State experienced difficulties in tracking Federal dollars during the two-year expenditure cycle. States are in no case allowed to draw funds from SAMHSA greater than the amount allocated.

8 Arizona, for example, utilized "life skills development" and "parent/family services" programs to address the "Education" strategy area.
In FFY 1993-1995, States had the option of addressing each of the six strategies through the use of State funds. Therefore, the strategy expenditure charts in each of the individual State profiles – which were reported in SAPT Block Grant applications – will occasionally show no expenditure when that strategy area was, in fact, addressed with State funds.

9 Our analysis revealed that in the FFY 1993 "transitional" year, only two States (North Dakota and South Carolina) showed discrepancies between the sum of the six CSAP strategies and the total 20% set-aside amount.

10 Office of National Drug Control Policy (1989), in Promising Practices in Community Prevention, submitted to Substance Abuse Services Prevention Branch, Department of Human Resources, State of North Carolina, by Associates for Human Potential, Inc., Sudbury, MA.

11 Promising Practices in Community Prevention, (1989), pages 6-7.

12 One of these States – Oregon – utilizes performance-based contracting with its provider network. Local providers in that State are accountable for outcomes measurements in four realms:

- Impact/process – A measurable number of programs are provided that impact a measurable number of recipients.
- Educational – A measurable amount of recipients demonstrate a gain in knowledge or engage in prevention activities.
- Attitudinal – Public school students report more negative attitudes toward alcohol, tobacco, and other drugs.

- Behavioral – Measurable outcomes include fewer disciplinary actions, referrals, and absenteeisms reported by public school staff.

Case studies

As we survey the prevention landscape across the United States, some specific prevention strategies in certain States may be highlighted as "best practice" models. These case studies are meant to educate the reader about Block Grant-funded prevention programs that are both innovative and successful.

Ohio's award-winning programs deliver urban- and rural-focused prevention strategies.
The Ohio Department of Alcohol and Drug Addiction Services (ODADAS) has been serving Ohio citizens with a comprehensive approach to alcohol and other drug addiction since its inception in 1989. ODADAS plans, initiates, and coordinates an extensive system of alcohol and other drug addiction services designed to prevent abuse and treat Ohio's addicted populations. The Department, by law, coordinates the alcohol and other drug services of State departments, the criminal justice system, law enforcement, the legislature, local programs, and treatment/prevention professionals throughout the State. The Department's mission is to "promote, assist in developing, and coordinate or conduct programs of education and research for the prevention of alcohol and other drug addiction and for the treatment, including intervention, of alcoholics and persons who abuse drugs of abuse. Programs established by the Department shall include abstinence-based prevention and treatment programs." ODADAS defines prevention as a "planned process of approaches and activities designated to preclude the onset of alcohol and other drug problems and/or addictions."

Ohio, through programs such as the Ohio Teen Institute, Urban Minority Alcoholism and Drug Abuse Outreach Programs, and the Ohio Youth Mentoring Program, offers its residents a comprehensive, community-based continuum of prevention services.

ODADAS has been the recipient of several Exemplary Substance Abuse Prevention Program Awards from the Center for Substance Abuse Prevention (CSAP). The State, through programs such as the Ohio Teen Institute, Urban Minority Alcoholism and Drug Abuse Outreach Programs, and the Ohio Youth Mentoring Program, offers its residents a comprehensive, community-based continuum of prevention services. The Ohio Teen Institute, initiated in 1965, is one of the longest-running adolescent peer prevention programs in the United States, and has served as a model for similar programs in more than 36 States. The retreat is held annually at Kenyon College in Gambier; in 1997, the event drew over 400 teens and 100 adults. The adolescents are taught leadership techniques to promote alcohol and other drug prevention in their homes and communities.

Urban Minority Alcoholism and Drug Abuse Outreach Programs are designed to serve prevention and intervention needs specific to African- and Hispanic-American communities. These programs – unique in the U.S. – have become an integral part of the continuum of services that impact approximately 80 percent of all African- and Hispanic-American citizens in Ohio. Collectively, these programs provide culturally-specific and bilingual alcohol and other drug prevention services for youths, senior citizens, public housing communities, churches, schools, and grassroots organizations. The programs also contain a component that provides drug prevention training on the local, State, and National levels. Recently, a statewide abstinence-based teenage pregnancy prevention program was implemented. Each program has hired teens as peer educators who implemented the program in schools, churches, recreation centers, and other community-based organizations.

The Ohio Youth Mentoring Program, implemented in January 1997, consists of four pilot programs throughout the State (14 programs were planned for State Fiscal Year 1998). These adult-to-youth mentorships offer adolescents skills to increase their resiliency and promote self-empowerment to avoid alcohol, tobacco, and other drugs. The youth are also taught skills designed to prevent them from becoming involved in violence, juvenile crime, and school failure.

ODADAS allocates its 20% set-aside to a network of 50 Community Service Boards, which in turn provide oversight to over 350 local prevention programs, 275 of which receive Block Grant funds. Seven of the Boards serve the State's metropolitan regions and provide substance abuse-related services exclusively; the remaining Boards provide both substance abuse and mental health services throughout the State's rural regions.

Washington State's prevention programs are based on the risk/protective model.
As in Ohio, the State of Washington utilizes a regionally-based prevention system. The Division of Alcohol and Substance Abuse (DASA) – one-third of which is devoted to treatment and prevention activities – allocates most of the State's prevention set-aside funds to all 39 counties in the State. DASA has directed its network of local substance abuse treatment and prevention providers to transition from a program-based emphasis to a risk/protective factor-based model of service delivery. Subsequently, prevention strategies at the local level have begun to address high-priority risk factors and to include the enhancement of protective factors.

In Washington State, prevention programs at the local level address high-priority risk factors and include the enhancement of protective factors.

The premise of the risk and protective factor model is that in order to prevent a problem before it occurs, it is necessary to address those factors that predict the problem. Prevention, as applied to alcohol, tobacco, and other drugs, focuses on "risk factors" that place children and adolescents in danger of the problem behaviors related to the use and abuse of these substances. These are factors that, if present in a child's life, increase the probability that the child will abuse alcohol and other drugs during adolescence. Similarly, protective factors, if in a child's life, assist in insulating the child

from the effects of risk factors present in his/her environment. When it is not possible to affect risk factors, prevention efforts target "protective factors" in order to buffer the individual from the impact of risk factors.

The risk/protective factor approach to prevention has applicability to other areas of prevention beyond substance abuse. Many of the risk factors for adolescent substance abuse are also indicators for teenage pregnancy, adolescent delinquency, violence, and school drop-out. Consequently, other programs, such as Washington State's teenage pregnancy prevention program, have indicated interest in applying this model to their specific programs.

Washington State providers augment their prevention services with programming in alignment with several domains that are based on the risk/protective factor model: family domain, school domain, community domain, and individual/peer domain. DASA has designed a database that manages information within 17 risk factors and 106 specific indicators for substance abuse (as of 1996). DASA collects statewide and county-by-county data for each indicator. The table below lists some of the risk factors, and their associated indicators (as reported by the State), in the four domain areas the State has developed.

DOMAIN	RISK FACTOR	INDICATOR
Community *The more available drugs are in a community, the higher the risk that young people will abuse drugs.*	Availability of drugs	Alcohol retail licenses
	Transitions and mobility	Existing home sales
Family *If children are raised in a family with a chronic history of addiction to alcohol or other drugs, or a history of recurring criminal behavior, their own risk of having alcohol (or other drug) problems increases.*	Family conflict	Divorce rates Domestic violence arrests
	Favorable parental attitudes and involvement in crime/drugs	Adult drunken driving arrests Adult violent crime arrests
School *Low commitment to school means the young person has ceased to see the role of student as a viable one.*	Academic failure	GED diplomas issued Poor academic performance
	Early and persistent antisocial behavior	School survey measure of antisocial behavior

Individual/peer *Young people who feel they are not part of society, are not bound by rules, do not believe in trying to be successful or responsible or who take an active rebellious stance toward society are at higher risk of drug abuse.*	Favorable attitudes toward substance abuse	School survey measure for personal attitudes toward substance abuse
	Constitutional factors	School survey measure for sensation seeking

Protective factors identified by DASA, and recently quantified in the *1995 Washington State School Survey*, include:

- Community rewards for conventional involvement
- Family rewards for conventional involvement
- School rewards for conventional involvement
- Opportunities for positive involvement in the family
- Opportunities for positive involvement in school
- Belief in the moral order
- Social skills

The indicators that are used to measure these specific protective factors are quantified via statewide school surveys.

Programs that receive Federal set-aside funds offer prevention services in all six CSAP-identified strategy areas; approximately 58% of these programs are devoted to prevention education. DASA recognizes that there are several research-based prevention approaches/strategies that have been shown to be effective in reducing risk factors and enhancing protective factors. These programs address risk factors at appropriate developmental stages; enhance bonding to groups/individuals who promote healthy behaviors, beliefs, and standards; promote both cognitive and social skill development; and use intervention techniques which have empirically demonstrated positive effects either in reducing substance abuse, risk factors for substance abuse, or other poor behavioral outcomes. Some noteworthy prevention programs include:

- Preventing drug abuse in the elderly – This campaign, launched in 1995, has raised awareness among the elderly regarding the dangers of combining prescription medications or over-the-counter drugs with alcohol. The campaign components have included radio ads in English and Spanish, brochures, and print ads.

- Drug-free workplace programs – Initially limited to drug testing in the 1980s, drug-free workplace programs have evolved into a continuum of services. Through a contract with Washington Drug Free Businesses, DASA has assisted employers in starting drug-free business programs. County prevention specialists have also been involved in educational presentations to employees. The concept of prevention in the

workplace has included the prohibition of drugs at work, as well as primary prevention efforts, such as parenting education.

- Community prevention training system – This system has been designed to accept applications for funding prevention training programs from county and Native American programs. For instance, the Jamestown S'Kallam Tribe was awarded a grant to provide training for tribal youth. The youth were taught skills designed to enhance their spiritual and cultural lives, and were taught techniques for competing in the "off-reservation" world.

Outcomes-based prevention programming is utilized by Iowa providers.

In the mid-1990s, Medicaid funding was integrated with the treatment portion of Iowa's Substance Abuse Prevention and Treatment Block Grant. The Division of Substance Abuse and Health Promotion (DSAHP) subsequently contracted with a managed behavioral health care organization for the provision and administration of behavioral health care services. At the same time, the prevention provider system, which was not placed under the managed care contract, also underwent significant changes. Primary among these changes was the transition from a process-based reporting system to an outcomes-based planning and grant solicitation system for prevention services.

The Iowa Division of Substance Abuse and Health Promotion has transitioned from a process-based reporting system to an outcomes-based planning and grant solicitation system for prevention services.

This transition enabled DSAHP to move from a paper-based reporting system to an electronic tracking process. The provision of outcomes data has been central to enabling prevention specialists to identify and address potential problem indicators within their service areas. In fact, prevention providers have been required to reference baseline data concerning their selected target populations as part of the request for proposals (RFP) process.

DSAHP subscribes to the public health model of prevention, in which substance abuse is viewed as an illness or disease. Although specific subpopulations are targeted for prevention services – depending on the outcome of local needs assessments – DSAHP in effect targets all Iowans from pre-birth to death. A research consortium has been formed that includes faculty members from four Iowa universities who will assist DSAHP in conducting a three-year comprehensive needs assessment. This needs assessment, which will include surveys of parents, teachers, and school personnel, serves as an adjunct to local needs assessments conducted by the 23 regional prevention programs across the State.

Texas has developed model prevention programs aimed at youth.

In Texas, prevention programs promote a proactive process to address and promote health and wellness for individuals, families, and communities by enhancing protective and resiliency factors, and by averting and precluding negative factors which place

individuals at risk for substance abuse. Intervention programs offer constructive methods designed to interrupt the onset or progression of substance abuse in the early stages. Four basic premises guide prevention and intervention in the State:

- Prevention and intervention programs must be comprehensively structured to reduce individual and environmental risk factors and to increase resiliency factors in high-risk populations.
- Community involvement is a necessary component of an effective prevention program. A shared relationship among all parties is essential in the promotion of alcohol, tobacco, and other drug prevention and intervention efforts.
- Prevention and intervention shall be intertwined with the general health care and social services delivery systems, and it shall provide for a full continuum of services.
- Prevention and intervention approaches and messages that are tailored to differing population groups are most effective.

Many of the prevention programs focus on youth, and the Texas Commission on Alcohol and Drug Abuse (TCADA) has created model prevention programs targeted at junior high school students. These programs, which are managed by the Youth Prevention Services Coordinator, have been implemented in each of the State's 11 substate regions. The programs aim to delay the onset of (or reduce) alcohol and drug use, assist children in developing their interpersonal relationship skills, reduce aggressiveness, and reduce conduct disorders. These programs, collectively known as the Model Programs Initiative, have been designed to expand knowledge about effective prevention models and enhance prevention efforts for youth and their families across the State. These programs implement the CSAP strategies of prevention education, alternative activities, and problem identification/referral. The table below lists these programs, plus the settings in which they are offered and the desired outcomes:

The Texas Commission on Alcohol and Drug Abuse has created model prevention programs . . . that aim to delay the onset of or reduce alcohol and drug use.

PROGRAM	SETTING	DESIRED OUTCOME
Life skills training program	School-based Community-based	Reduced alcohol, tobacco, and marijuana use
All stars program	School-based Community-based	Delayed onset of (and reduction in) alcohol and drug use; decreased violence; delayed onset of sexual activity
Promoting alternative thinking strategies	School-based	Increased self-control, emotional understanding, interpersonal relationship skills, cognitive problem-

		solving
Preparing for the drug free years	School-based Community-based	Positive effects on parents' child management practices (e.g., standard-setting, monitoring, disciplining) and on parent/child affective quality
Strengthening families program	School-based Community-based	Improved youth resistance to peer pressure toward alcohol use, reduced affiliation with anti-social peers, reduced levels of problem behaviors
Reconnecting youth program	School-based	Improved school performance, school bonding, self-esteem, reduced drug involvement, reduced depression, reduced aggression

Each of the prevention programs has been tested for effectiveness in other States through research projects funded by the National Institute on Drug Abuse (NIDA). Community-based providers collaborate with TCADA to tailor these model programs to meet the needs of the target populations.

TCADA tracks drug and alcohol use among youth by the following methods:

- School surveys – one of these, the Texas School Survey, is a biannual collaboration between TCADA and the Public Policy Research Institute at Texas A&M University.
- Client-Oriented Data Acquisition Process database – this database contains information on all clients entering TCADA-funded substance abuse treatment programs.
- Arrest/crime data